2010 Medical Benefits Highlights – Seattle Police Officers' Guild

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
No deductible	$200 per person $600 per family Deductible applies except for prescriptions, preventive visits, ambulance, and durable medical equipment, except as noted.	$100 per person $300 per family	$150 per person $450 per family	Does not apply	$250 per person $750 per family
Annual Out of Pocket Maximum (OOP Max) Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max.					
$750 per person $1,500 per family	$2,000 per person $6,000 per family	$400 per person. Applies to 20% coinsurance.	$1,600 per person. Applies to 40% coinsurance. *	$500 per person $1,000 per family	$3,000 per person* $6,000 per family*
Maximum Lifetime Benefits Payable					
Combined $2,000,000 lifetime maximum for Standard and Deductible plans		Combined $2,000,000 lifetime maximum in- and out-of-network for Traditional and Preventive plans			
Hospital Copay					
Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%	Paid at 100%
Hospital Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.		Aetna contracted provider members. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES					
Acupuncture					
Paid at100%. 8 visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 100% after $20 copay. 8 visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 80% Maximum of 12 visits per calendar year for in- and out-of-network combined.	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Alcohol/Drug Abuse Treatment					
Paid at 100% after $200 copay	Paid at 100%	Paid at 80%	Paid at 80%	Paid at 100% after $5 copay.	Paid at 70%
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80%		Paid at 100%	Paid at 70%
Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100%.	Paid at 100% after $20 copay	Paid at 100% after $35 copay	Paid at 60%	Paid at 100% after $35 copay (no fee for preventive care)	Paid at 70%.
➢ **Emergency Room (copays waived if admitted)**					

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
GHC facility: Paid at 100% after $25 copay (waived if admitted). Non-GHC facility: Paid at 100% after $75 copay (waived if admitted.)	GHC facility: Paid at 100% after $75 copay (waived if admitted). Non-GHC facility: Paid at 100% after $125 copay (waived if admitted.)	Paid at 80%.	Paid at 80%. Non-emergency, paid at 60%.	Paid at 100% after $50 copay	Paid at 100% after $50 copay. Non-emergency paid 70% after $50 co-pay.
➢ **Ambulance**					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary.		Paid at 100% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Home Health Care					
Paid at 100% when authorized. No visit limit.	Paid at 100% when authorized. No visit limit.	Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.		Paid at 100% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.	Paid at 70%
Hospital Inpatient					
Covered in full.	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Hospital Outpatient					
Covered in full.	Paid at 100% after $20 copay	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 100%	Paid at 70%
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 90%		Paid at 100%. Maximum of 6 months for inpatient and outpatient combined. Additional 6 months available if authorized.	Not covered
Maternity Care (delivery & related hospital)					
Paid at 100%.	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (prenatal and postpartum)					
Paid at 100% .	Paid at 100% after $20 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid 100% after $5 copay	Paid at 70%
Mental Health Care (inpatient)					
No limit. Covered in full.	No limit. Covered in full	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Mental Health Care (outpatient)					
Paid at 100%.	Paid at 100% after $20 copay	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%.
Physician Office Visit					
Paid at 100%.	Paid at 100% after $20 copay	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%

Prescription Drugs (retail)					
For a 30 day supply: $3 copay. Contraceptive drugs and devices are subject to the pharmacy copay. Copays do not apply to the out-of-pocket maximum.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the out-of-pocket maximum.	For a 34-day supply: **Generic**: $5 copay Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units. Preferred brand-name: $10 copay. Non-preferred: $25 copay. Many contraceptive products are covered. IUS and Depo Provera are covered under the medical plan benefits. Copays do not apply to out-of-pocket maximum. Pharmacy out-of-pocket maximum of $1,200 per individual or $3,600 per family.	Not covered	For a 31-day supply: **Generic**: $5 coapy **Preferred brand name:** $10 copay. Non-preferred drugs: $25 copay. Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum. Pharmacy out-of-pocket maximum of $1,200 per individual or $3,600 per family.	Not covered
Prescription Drugs (mail order)					
Mailing service available, subject to a $3 copay per 30-day supply. Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: Generic: $30 copay Brand: $60 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: Generic: $10 copay Preferred brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered	For a 90-day supply: Generic: $10 copay Preferred brand name: $20 copay Non-preferred drugs: $50 copay	Not covered
Preventive Care					
Paid at 100% . Most immunizations, hearing exams, eye exams, mammograms.	Paid at 100% after $20 copay. For preventive care visits, most immunizations, mammograms and eye exams not subject to deductible. Hearing exams are subject to deductible.	Paid at 80% for mammograms. Other preventive services not covered.	Paid at 60% for mammograms. Other preventive services not covered.	Paid at 100% for routine physical exams, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services are covered.
Rehabilitation Services (inpatient)					
Paid at 100% Maximum of 60 days per calendar year for all types of rehabilitation.	Paid at 100% Maximum of 60 days per calendar year for all types of rehabilitation.	Paid at 80% Lifetime maximum of $50,000 per condition for in-network and out-of-network combined.	Paid at 60%	Paid at 100% Maximum 120 days per calendar year for in- and out-of-network combined.	Paid at 70% after $200 copay
Rehabilitation Services (outpatient)					
Paid at 100% Maximum of 60 visits per calendar year for all types of rehabilitation.	Paid at 100% after $20 copay Maximum of 60 visits per calendar year for all types of rehabilitation.	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum. Maximum calendar year benefit of $2,000 for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $5 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Out-of-network coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits for each of the above listed benefits per calendar year for in-network and out-of-network combined.	Paid at 70%

Skilled Nursing Facility					
Paid at 100%. 60 day maximum per calendar year.	Paid at 100%; 60 day maximum per calendar year.	Paid at 80% Maximum $600 per occurrence Maximum of 90 days per calendar year for in- and out-of-network combined.	Paid at 60% Maximum of $600 per occurrence	Paid at 100% Maximum of 120 days per calendar year for in- and out-of-network combined	Paid at 70%
Smoking Cessation					
Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No co-pay for all smoking cessation prescription drugs.	Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No copay for all smoking cessation prescription drugs.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered.	Not covered.	Not covered
Spinal Manipulations					
Paid at 100% Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 100% after $20 copay. Self-referral to GHC designated providers. Must meet GHC protocol.	Paid at 80% Maximum of 10 visits per calendar year for in-network and out-of-network combined		Paid at 100% after $5 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 70%
Sterilization Procedures					
Covered in full	$20 copay	Paid at 80%	Paid at 60%	Inpatient: Paid at 100%	Paid at 70%
Tooth Injury (due to accident)					
Not covered.	Not covered	Paid at 80%		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%
Vision					
Hardware: $100 per 24 month period. Vision exam: Covered in full Coverage also provided under Vision Service Plan.	Hardware: not covered Vision exam: Paid at 100% after $20 copay Coverage also provided under Vision Service Plan.	Covered under Vision Service Plan.		Covered under Vision Service Plan.	
X-ray and Lab Tests					
Paid at 100%	Paid at 100%.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

Plan details are your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp**. This document is not a contract.**